



Potential Impact of Health Reform on Rural North Dakota Health Workforce

Overview

The **Patient Protection and Affordable Care Act (ACA)**, was enacted in March 2010. This sweeping piece of national legislation is regarded as the most significant since the enactment of Medicare and Medicaid in 1965. The ACA has as its three primary goals to:

1. Provide universal coverage to U.S. citizens involving a shared responsibility between the private sector, public sector, employers, and individuals
2. Improve the quality of care and overall public health of the citizenry through changes in the health care delivery system with an emphasis on linking health organization performance, patient outcomes, care coordination, prevention and wellness, and provider accountability with new payment structures; and
3. Change the cost curve of health care expenditures to lower the rate of growth in costs. This fact sheet is the first in a series that will look at the implications of the ACA on rural health. First up is addressing a long standing health system issue: health workforce. The ACA seeks to increase the number of providers, enhance training opportunities, strengthen local capacity, improve care coordination, develop more strategic and comprehensive understanding of health workforce needs and potential, and emphasize the importance of primary care.

Health Workforce is an Issue in Rural North Dakota

Health workforce is a significant issue facing North Dakota. Two research efforts conducted by the Center for Rural Health^{1,2} to identify rural health issues found health workforce to be a consistent and fundamental impediment to a strong rural health delivery system. For example, eighty-nine percent of North Dakota is designated by the federal government as a primary care Health Professions Shortage Area (HPSA).

Twenty-three North Dakota counties have been classified as persistent whole county primary care HPSAs that have retained the HPSA designation for at least seven years. Nationally, counties with this designation have the lowest primary care physician supply, the lowest percentage of rural adults with a regular primary care provider, and are the most likely to forego needed health care due to cost.³ Nationally, the average vacancy rate for physicians in hospitals is 11 percent; however, the vacancy rate found in North Dakota was over 16 percent.³

Access to an adequate supply of health care providers is a concern in both North Dakota and nationally. By 2012, seven of the top ten fastest growing occupations across the nation are projected to be in health care. Center

for Rural Health projections indicate that by 2020, about one-third of the state's physicians will be at a likely age of retirement, with the percentage being slightly lower for primary care in comparison to non-primary care.³ About 90 percent of North Dakota physicians are located in the ten largest cities; over 83 percent of the primary care physicians are located in those cities.³ However, according to the USDA Economic Research Service, the 2009 population estimate for North Dakota recorded 51 percent of the state's population as rural; thus, about nine out of ten physicians are practicing in essentially urban areas of the state, and about five out of ten North Dakotans are either urban or rural.⁴ Regarding other health care disciplines, Job Service of North Dakota expects significant growth (over ten percent) in demand for pharmacists, occupational therapists, physical therapists, medical and clinical laboratory technologists and technicians, physician assistants, and registered nurses.²

The ACA devotes significant new federal resources to addressing health workforce issues which will have impact on rural health providers, employers, educators, health disciplines, associations, and others. The following summarizes some of those key features.

Factors Influencing North Dakota's Rural Health Workforce

- ❖ Aging population creating increased demand for services
- ❖ Geographical barriers (i.e., distance, isolation, driving conditions, two-thirds of counties are designated frontier) exacerbate access to necessary services
- ❖ Growing rates of chronic disease creating increased need for care management and coordination
- ❖ Increasing needs associated with improving the quality of care and corresponding measurement, improving medical outcomes, improving health organizational performance, and efforts linking payment with outcomes
- ❖ Mal-distribution of some provider groups between urban and rural
- ❖ Workload demands and expectations for rural providers can be greater than urban (call schedules, time off, flexibility, impact on family life)
- ❖ Aging of health workforce personnel
- ❖ Physicians selecting non-primary care medical disciplines
- ❖ Private and public payment structures and reimbursement
- ❖ Opportunities for rural-based training
- ❖ Availability of career ladder opportunities to facilitate career transitions in an effort to support rural “grow-your-own” efforts
- ❖ Attitudes of health professionals toward practicing in rural communities
- ❖ Financial viability of rural health facilities and organizations, along with issues associated with an aging physical plant and capital found in rural hospitals
- ❖ Availability and affordability of technology including Health Information Technology (HIT)
- ❖ Efforts to develop awareness and interest in K-12 grade students for careers in health care

Source: Center for Rural Health, UND School of Medicine and Health Sciences, 2011

Affordable Care Act Health Workforce Major Provisions

National Health Service Corps

Increased funding to the NHSC to support loan repayment and scholarships for physicians, nurses, nurse practitioners, dentists, physician assistants, and others. The program is modified to allow participants to complete some of their obligated service through their clinical practice time while in residency which will make the program more attractive to candidates. In addition, amounts received through the NHSC are to be excluded from federal tax obligations, which is also an inducement to participate in the program.

Workforce Commission

The ACA establishes a National Health Care Workforce Commission to develop a comprehensive and coordinated national strategy to address workforce shortages and encourage training in key focus areas that support delivery system reform goals, such as improving care coordination, health provider use of health information technology, and increasing access to primary care services. The commission will work across federal department lines to better plan and coordinate federal efforts, and will work with state and local entities.

State Health Care Workforce Development Grants

Planning grants of up to \$150,000 for one year will be available to states to develop coherent and comprehensive health care workforce development strategies. States would be eligible for two year implementation grants. The establishment of regional partnerships promoting career pathways can support rural-based opportunities.

Health Care Workforce Assessment

The Act establishes a National Center for Health Care Workforce Analysis to develop information describing and analyzing the nation's health workforce, with corresponding state and/or regional assessment centers. These national, state, and regional assessment centers can include rural-focused data.

Rural Physician Training Grants

To increase the number of training programs and opportunities in medical disciplines important in rural areas, the ACA establishes a grant program to recruit students most likely to practice in underserved rural communities, provide rural focused training, and increase

the number of graduates who practice in rural communities. Priority to be given to program applicants with a record of training individuals from underrepresented minority groups, a rural or disadvantaged background, successfully training students who practice in rural communities, rural community institutional partnerships, and a plan to track the location of the practice of graduates.

Primary Care Extension Program

The purpose of this program is to support and assist primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques. Grants will be made to states for state or multistate-level Primary Care Extension Program State Hubs. Primary Care Extension Agencies shall assist primary care providers to implement patient-centered medical homes and improve accessibility, quality, and efficiency of primary care services.

Mental and Behavioral Health Education and Training Grants

Grants are available to institutions of higher education to support the recruitment, education, and clinical experience of students in social work and psychology, and to organizations to pay for

programs for pre-service or in-service training of paraprofessional child and adolescent mental health workers.

Distribution of Additional Medical Residency Positions

After July 1, 2011, urban hospitals that have unfilled residency slots, for three consecutive years, will lose 65 percent of the number of unfilled positions. The unfilled slots will be resigned to other hospitals with 75 percent of the reassigned positions being set aside for primary care and general surgery residencies. Priority will be given to hospitals in states with the lowest resident to population ratio, hospitals in the ten states with the highest ratios of population living in a health professional shortage area to population not living in a HPSA (which includes North Dakota), and hospitals in rural areas. In order to be eligible, a hospital receiving the training slots must have an accredited rural training track.

Interdisciplinary Community-Based Linkages

The ACA establishes two new grant programs for Area Health Education Centers (AHECs). One is for infrastructure development to initiate health care workforce educational programs or continue comparable programs by planning, developing,

ACA Key Approaches to Address Rural Health Workforce Issues

- ❖ Improved education and training efforts with either additional or new funds for medical students and residents, nursing, public health, nurse practitioners, physician assistants, allied health, and dentistry
- ❖ Renewed emphasis on rural-based training options and resources
- ❖ Development of a national vision for health workforce with enhanced coordination, collaboration, and evaluation
- ❖ Renewed emphasis on information, data analysis, and projections to support workforce planning at the national and state levels
- ❖ Increased support to state government, academic programs, and overall state efforts to address health workforce needs
- ❖ Recognition and support of efforts to improve medical and health science education relative to chronic disease, care coordination and management, disease prevention and wellness
- ❖ Recognition and support to projects that emphasize rural and/or underserved communities efforts to “grow-your-own” local health professionals
- ❖ Strengthened opportunities for pilot or demonstration efforts intended to develop and test models that can be responsive to rural health needs and inclusive of rural health participation
- ❖ Improved incentives (at a state, community, health system, and academic levels) to increase the number of health professionals for a restructured health care system built around primary care
- ❖ Inclusion of a broader array of health disciplines recognizing their contribution to building a stronger rural health system
- ❖ Increased bonus payments to rural providers (physicians, physician assistants, and nurse practitioners) in underserved areas and some equity adjustments for rural physicians relative to urban.

Source: Center for Rural Health, UND School of Medicine and Health Sciences, 2011

and evaluating an AHEC program; a second is to maintain and improve effectiveness and capabilities of existing AHEC programs.

Nursing Student Loan Program

The level of funds per student for loan repayment is increased.

Nurse Education, Practice, and Retention Grants

Grants for a career ladder program for individuals to become baccalaureate prepared registered nurses or advanced education nurses, to develop and implement internships and residency programs, and to assist individuals in obtaining the education and training required to enter the nursing profession and advance within the profession. These grants can be used to support rural hospitals and clinics efforts to "grow-your-own" by supporting new educational advancement for local residents.

Public Health Workforce Recruitment and Retention Program

A new effort to support public health workforce development is established. This program could help staff local public health departments in rural locations.

Allied Health Workforce Recruitment and Retention Program

A new loan program is developed for allied health professionals which can include a variety of technicians and technologists, paramedics, physical therapy, occupational therapy, respiratory therapy and others.

Training Opportunities for Direct Care Workers

Grants are to provide new training opportunities for direct care workers in long-term care settings (nursing homes, assisted living and skilled nursing facilities, intermediate care facilities, home- and community-based settings).

Alternative Dental Health Care Providers Demonstration Program

To address dental shortage issues, the ACA establishes demonstration grants to be competitively awarded to 15 entities to establish programs to train or employ alternative health care providers to increase access in rural and other underserved communities.

Bonus Payments to Existing Providers in Rural and/or Underserved

Provides a ten percent Medicare bonus for fee schedule for primary care (including physician assistants/nurse practitioners) over five years

for certain areas related to home, office, nursing facility, and hospital visits. The Act provides a ten percent add-on bonus for general surgeons performing major surgery in a health professional shortage area. The Act provides, in 2010, a five percent bonus for mental health physicians.

Geographic Practice Cost Index

Extends, but not permanently, the cost index adjustment to place rural physicians on par with urban physicians for Medicare.

Payments to Primary Care Physicians

Starting in 2013, Medicaid fees for primary care services will be paid at equal to those of Medicare. There are about 65 federally certified Rural Health Clinics in North Dakota. This provision could be supportive to rural health systems such as vulnerable RHCs and rural hospitals operating such clinics.

Sources

- ¹ North Dakota Flex Program & Critical Access Hospital State Rural Health Plan, Center for Rural Health, 2008. Full report available at ruralhealth.und.edu/projects/flex/pdf/state_rural_health_plan112608.pdf
- ² An Environmental Scan of Health and Health Care in North Dakota Establishing the Baselines for Positive Health Transformation, Center for Rural Health, 2009. Full report available at ruralhealth.und.edu/projects/escan/pdf/vol1-2.pdf
- ³ The University of North Dakota School of Medicine and Health Sciences, program data, 2010.
- ⁴ USDA Economic Research Service. Information is available at www.ers.usda.gov/statefacts/ND.HTM

For more information, contact Brad Gibbens, MPA, at the Center for Rural Health.
701.777.2569 • brad.gibbens@med.und.edu

Center for Rural Health

The University of North Dakota
School of Medicine & Health Sciences
501 North Columbia Road, Stop 9037
Grand Forks, ND 58202-9037
Tel: 701.777.3848 • Fax: 701.777.6779
ruralhealth.und.edu

